BEFORE THE ARIZONA MEDICAL BOARD

In the Matter of **ERICK R. MARTINEZ, M.D.** Holder of License No. **20874** For the Practice of Allopathic Medicine In the State of Arizona.	Board Case No. MD-06-0292B **FINDINGS OF FACT, CONCLUSIONS OF LAW AND ORDER** (Letter of Reprimand)

The Arizona Medical Board ("Board") considered this matter at its public meeting on February 8, 2007. Erick R. Martinez, M.D., ("Respondent") appeared before the Board with legal counsel Gordon Lewis for a formal interview pursuant to the authority vested in the Board by A.R.S. § 32-1451(H). The Board voted to issue the following Findings of Fact, Conclusions of Law and Order after due consideration of the facts and law applicable to this matter.

FINDINGS OF FACT

1. The Board is the duly constituted authority for the regulation and control of the practice of allopathic medicine in the State of Arizona.

2. Respondent is the holder of License No. 20874 for the practice of allopathic medicine in the State of Arizona.

3. The Board initiated case number MD-06-0292B after being notified of a medical malpractice settlement regarding Respondent's care and treatment of a thirty-two year-old female patient ("RT") alleging Respondent failed to instruct or communicate with RT and her family during and after delivering her baby and that he failed to perform a requested tubal ligation. Unaware the tubal ligation was not performed, RT subsequently became pregnant and delivered in 2003.

4. RT was under Respondent's care during a pregnancy. In her third trimester Respondent determined RT had a transverse lie of her fetus and, because she had a history of bicornuate uterus, she and Respondent decided she would have a scheduled cesarean section

("C-section") on November 13, 2002 when she would be at 39 weeks gestation. On November 8, 2002 RT was seen in Respondent's office and a note was made that she desired a tubal ligation with the C-section. RT signed a consent for the procedure on this same date. RT saw Respondent again on November 11 and he noted her desire for the tubal ligation. On November 12 RT was admitted to the hospital at 0334 with spontaneous rupture of membranes in breech presentation in labor, dilated to 8-9 centimeters. Respondent obtained a permit at the hospital for the C-section, but not for the tubal ligation. Respondent performed an emergent C-section and accomplished delivery at 0416. Respondent did not perform the tubal ligation. Respondent saw RT post-operatively and had no discussion with her about the tubal ligation or contraception.

5. RT signed the consent for the tubal ligation on November 8 and met with Respondent on the 11th. Respondent's office had not processed the consent or sent it to the hospital by the 12th when RT went into labor. Respondent regrets the communication lapse that occurred when RT presented to the hospital in an emergent situation and he has since modified his office policies, including chart management and scheduled communication with the hospital, to alleviate the communication issues. Respondent has also implemented an electronic medical records system with access from the hospital so all patient information is readily available to him while he is at the hospital.

6. At the time of RT's care the process in Respondent's office for scheduling a requested procedure was that a scheduler prepared all the paperwork and sent it to the hospital requesting the procedure and, when the patient presented to the hospital, the paperwork was available and ready. Because RT presented and discussed the tubal ligation with Respondent on November 11 and went into labor sometime that evening the paperwork was not available at the hospital. When Respondent performs emergency C-sections he does not usually perform tubal ligations because he does not know what the baby's outcome will be and he wants to preserve the patient's fertility. When RT presented for the emergency C-section she signed a consent for

that procedure at the hospital. Respondent saw this consent but, because of the emergent nature of the procedure, did not notice there was no consent for a tubal ligation.

7. The nurse's discharge form in the hospital record indicates that when RT was discharged she and the nurse discussed birth control, but the record does not reflect whether the tubal ligation was discussed. When RT presented to Respondent for her post-partum visit his nurse noted "TBL" (tubal ligation) in the chart, under "Contraceptive Method," but there is no documentation that she was informed the procedure was not done. Respondent always discusses with his patients the procedures he performs and he did not discuss the tubal ligation with RT because he did not perform the procedure and RT did not bring it to his attention.

8. Respondent's chart contained the consent for the tubal ligation and Respondent's note that RT requested a tubal ligation. However, on RT's post-partum visit she was not informed Respondent had not performed the procedure. RT was under a spinal anesthetic during the C-section when Respondent performed an excision of a uterine septum. Excising a uterine septum is not commonly performed during a C-section, but Respondent believed it was the cause of RT's malpresentation and he assumed she would want it removed in order to have a future pregnancy. Respondent did not discuss this with RT even though she was conscious.

9. The standard of care required Respondent to obtain consent for the tubal ligation at the hospital when RT presented. When the consent was not obtained and, as a result he did not perform the procedure, the standard of care required Respondent to inform RT and discuss options for contraception.

10. Respondent deviated from the standard of care because he failed to obtain consent for the previously requested tubal ligation when RT presented at the hospital and failed to inform her he did not perform the procedure or discuss other options for contraception.

11. RT, who previously had difficult pregnancies was unaware the tubal ligation was not performed and became pregnant again. RT could have had complications during pregnancy due

to her genetic difficulties with pregnancy.

12. It is mitigating that the nurses, at discharge from the hospital when they are responsible for discussing birth control, missed the fact that the tubal ligation was not performed. It is also mitigating that Respondent changed his practice and now ensures the records are available at the hospital.

CONCLUSIONS OF LAW

1. The Arizona Medical Board possesses jurisdiction over the subject matter hereof and over Respondent.

2. The Board has received substantial evidence supporting the Findings of Fact described above and said findings constitute unprofessional conduct or other grounds for the Board to take disciplinary action.

3. The conduct and circumstances described above constitutes unprofessional conduct pursuant to A.R.S. § 32-1401(27)(q) ("[a]ny conduct or practice that is or might be harmful or dangerous to the health of the patient or the public.").

ORDER

Based upon the foregoing Findings of Fact and Conclusions of Law,

IT IS HEREBY ORDERED:

Respondent is issued a Letter of Reprimand for failing to inform the patient that a requested and consented to tubal ligation had not been performed during her emergent C-section delivery.

RIGHT TO PETITION FOR REHEARING OR REVIEW

Respondent is hereby notified that he has the right to petition for a rehearing or review. The petition for rehearing or review must be filed with the Board's Executive Director within thirty (30) days after service of this Order. A.R.S. § 41-1092.09(B). The petition for rehearing or review must set forth legally sufficient reasons for granting a rehearing or review. A.A.C. R4-16-103. Service of this order is effective five (5) days after date of mailing. A.R.S. § 41-1092.09(C). If a

petition for rehearing or review is not filed, the Board's Order becomes effective thirty-five (35) days after it is mailed to Respondent.

Respondent is further notified that the filing of a motion for rehearing or review is required to preserve any rights of appeal to the Superior Court.

DATED this 13th day of April 2007.

ARIZONA MEDICAL BOARD 1913 STATE OF ARIZONA

THE ARIZONA MEDICAL BOARD

By_____
TIMOTHY C. MILLER, J.D.
Executive Director

ORIGINAL of the foregoing filed this 13th day of April, 2007 with:

Arizona Medical Board
9545 East Doubletree Ranch Road
Scottsdale, Arizona 85258

Executed copy of the foregoing mailed by U.S. Mail this 13th day of April, 2007, to:

Gordon Lewis
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Phoenix, Arizona 85012-2703

Erick R. Martinez, M.D.
Address of Record